Case Name:
Case Number:
Date:
MDHHS Office:
Specialist / ID: /
Phone:
Fax:
Individual ID:

STATE OF MICHIGAN
Department of Health and Human Services

If you do not understand this, call an MDHHS office in your area. MDHHS employees are prohibited by law from providing legal advice.

Si ústed no entiende esto, llame a una oficina de MDHHS en su área. La ley prohíbe a los empleados de MDHHS proporcionar asesoría legal.

إذا واجهت صعوبة في فهم هذا الطلب، فاتصل بمكتب MDHHS الموجود في منطقتك.
إعطاء النصيحة القانونية MDHHS يحرم القانون على موظفي

ENTER ADDRESSEE NAME
ENTER ADDRESSEE CARE OF
ENTER ADDRESSEE PO BOX OR STREET
ENTER ADDRESSEE CITY/STATE/ZIP

MEDICAL NEEDS

INSTRUCTIONS: To be completed by a physician, physician assistant, nurse practitioner, clinical nurse specialist, physical or occupation therapist. In addition, Box A may be completed by a certified nurse midwife. Please print or type. Please complete page 1 to page 3.

Medical Provider: We would appreciate your cooperation in completing the spaces checked below. Providers must be Medicaid enrolled. An addressed, prepaid envelope is enclosed for your convenience.

You are hereby authorized to release the information requested below to the Michigan Department of Health and Human Services.

Patient's or Representative's Signature	Signature Date
Patient's Name	Patient's Birthday

☐ **A**	Pregnancy Delivery (Expected) Date	Number of medically verified unborn children
☐ **B**	Diagnosis(es) / Treatment plan for this patient	
☐ **C**	Chronic ongoing illness ☐ Yes ☐ No ▶	
☐ **D**	Estimated number of office or clinic visits ___ times per ☐ week ☐ month ☐ quarter ☐ Other (Please Specify) _____ Will this change? ☐ Yes, When _____ Date _____ ☐ No	
☐ **E**	Give estimated number of months for the diagnosis in B that medical treatment will be required ☐ Lifetime	
☐ **F**	Is the patient non-ambulatory? ☐ Yes ☐ No	If Yes, explain

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☐ **G**	Does the patient need special transportation? If Yes, indicate mode of transportation needed (e.g., van with wheelchair lift, ambulance, etc.) ☐ Yes ☐ No ▶	
☐ **H**	Does someone need to accompany the patient to the medical appointment? ☐ Yes ☐ No ▶	If yes, who / why?
☐ **I**	Do you certify the patient has a medical need for assistance with any of the personal care activities listed below? ☐ Yes ☐ No ▶	
	Eating Toileting Bathing Grooming	Dressing Transferring Mobility Taking Medications	Meal Preparation Shopping Laundry Housework
	Check any complex care services needed. ☐ Specialized Feeding ☐ Catheters or Leg Bags ☐ Colostomy Care	☐ Bowel Program ☐ Suctioning ☐ Bedsore Prevention	☐ Range of Motion ☐ Other _____
☐ **J**	Can patient work at usual occupation? ☐ Yes, but with limitations (Specify below)	☐ No (How long)
	Can patient work at any job? ☐ Yes, but with limitations (Specify below)	☐ No (How long)
☐ **K**	Other (Explain)	
☐ **L**	Is the spouse or parent of the above disabled individual (Needed in the home to provide care)? ☐ Yes ☐ No	(Cannot engage in work due to the extent of care required). ☐ Yes ☐ No

Date patient was last seen	Are you a Medicaid enrolled provider? ☐ Yes ☐ No	
Name and title (Print or type)	MA enrolled Provider Signature	
MA Provider ID Number	Signature Date	Telephone Number

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

AUTHORITY: Federal 45 CFR 233.20, CFR 440.10 and CFR 440.20
COMPLETION: Voluntary **PENALTY:** Benefits may be affected.